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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <u>Thelma Starfield Andrews</u>						2a. DATE OF DEATH Month <u>September</u> Day <u>6</u> Year <u>1968</u>			2b. HOUR <u>1A</u> M		
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>March 7, 1900</u>		6. AGE (In years last birthday) <u>68</u> YRS.		IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>		IF UNDER 24 HRS. HOURS <u> </u> MIN <u> </u>	
7a. BIRTHPLACE (State or foreign country) <u>Americus Georgia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>US</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Charles</u> Md.					
10. CITY OR TOWN OF DEATH <u>Indian Head</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>17 Potomac Avenue</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Prince Georges</u>			13b. COUNTY <u>Charles</u>		13c. CITY OR TOWN <u>Indian Head</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>17 Potomac Ave</u>		
14. FATHER'S NAME First <u>William</u> Middle <u>Stanfield</u> Last <u>Andrews</u>			15. MOTHER'S MAIDEN NAME First <u>Jane</u> Middle <u>Hembrow</u> Last <u>Andrews</u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>no</u> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>James E Andrews</u> Address <u>17 Potomac Ave Indian Head Md.</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>4-5 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u> </u> <u> </u> <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>January, 1968</u> , to <u>Sept.</u> , 1968, that (I) (we) lost saw the deceased alive on <u>Sept. 4</u> , 1968, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Frank A. Susan M.D.</u> DEGREE <u> </u> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <u>September 6, 1968</u>					
22d. PHYSICIAN'S NAME (Type) <u>Frank A. Susan M.D.</u>						22e. ADDRESS <u>Rt. 1 Box 50, Indian Head, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>9/10/1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Arlington, Va.</u>			
24. FUNERAL DIRECTOR <u>Arehart Funeral Home, Inc. - La Plata, Md.</u>						25a. REC'D BY REGISTRAR <u>SEP 10 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

2251

12853

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12864

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form P-13. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR	
EARL		LEONARD		BROWN				DATE KNOWN OF DEATH		2b. HOUR	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
Male	Colored	Nov. 4, 1939		28 YRS.		MONTHS		DAYS		2d. HOUR	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				2d. HOUR	
Pr. Geo. Co. Md.		U.S.A.				Charles				11p	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Patauxent City		Physicians Memorial Hosp.									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md.		Charles P. G.		Aguasquo		YES <input type="checkbox"/> NO <input type="checkbox"/>		Aguasquo, Md.			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Columbus		Brown						Alberta Pinkney			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
		217-36-5245		Columbus Brown Aguasquo, Md.		20608					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Bullet wound of the heart											
965x DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
981x											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
				9:50 P.M. 9 21 1968				Subject shot while in Toy's Inn			
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				Inn				Toy's Inn, Patuxent City Charles Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER				9/23/68			
Edward F. Wilson, M.D.				DEPUTY MEDICAL EXAMINER				ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial				Sept. 26/68		John Wesley Ch. Cem.		Aguasquo, Pr. Geo. Md.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Martell Adams Aguasquo, Md.				DATE OCT 1 1968				Charles Judge			

12881

2000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201, 12865											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) EVA First JANE Middle DAVIS Last						2a. DATE OF DEATH 9 Month 7 Day 60 Year			2b. HOUR 1:40 M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH March 1, 1888		6. AGE (In years (b) birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Charles Md.					
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Physicians Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during past of work or life, even if retired.) n/w		12b. KIND OF BUSINESS OR INDUSTRY At Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Charles		13c. CITY OR TOWN Marbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First George W. Middle Henderson Last				15. MOTHER'S MAIDEN NAME First Kate Middle Norman Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Miss. Frances Davis-Daughter-Marbury, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dissecting Aneurysm of aorta 796.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mesenteric Thrombosis DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9-6-68 59-7-68	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 795.0											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 9-6-68 to 9-7-68 that (I) (we) last saw the deceased alive on 9-6-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE E. J. Edelen M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9/7/1968					
22d. PHYSICIAN'S NAME (Type) E. J. Edelen, M.D.		22e. ADDRESS La Plata, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/9/1968		23c. NAME OF CEMETERY OR CREMATORY Nanjemoy Baptist Cemetery		23d. LOCATION (City or Town) Nanjemoy, Maryland		(County)		(State)	
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc.-La Plata, Md.		ADDRESS		25a. REC'D BY REGISTRAR SEP 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

13865

March 1, 1965

White

Spain

Contract

1965

Spain

Physician Hospital

Spain

Physician Hospital

Spain

Physician Hospital

Physician Hospital

Physician Hospital

Physician Hospital

Physician Hospital

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Physician Hospital

Physician Hospital

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

12855										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										12866																																																											
1. DECEASED-NAME (Type or Print) <i>Wills</i> KERNIEL										First Middle Last										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>9</i> Day <i>28</i> Year <i>1968</i>										2b. HOUR <i>1:58 PM</i>																																																	
3. SEX <i>M</i>										4. RACE <i>N</i>										5. DATE OF BIRTH <i>July 1, 1950</i>										6. AGE (In years last birthday) <i>18</i> YRS										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS HOURS MIN.										7c. DATE PRONOUNCED DEAD Month <i>9</i> Day <i>28</i> Year <i>1968</i>										2d. HOUR <i>3 PM</i>									
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>										7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH <i>Charles</i>										Md.																																							
10. CITY OR TOWN OF DEATH <i>Faulkner Md</i>										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Farming</i>										12b. KIND OF BUSINESS OR INDUSTRY <i>---</i>																																																	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Md</i>										13b. COUNTY <i>Charles</i>										13c. CITY OR TOWN <i>Newburg</i>										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER																																							
14. FATHER'S NAME First Middle Last <i>Joseph P. Dorsey</i>										15. MOTHER'S MAIDEN NAME First Middle Last <i>Katherine Inez Dorsey (Edelen)</i>										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>										16b. SOCIAL SECURITY NO. <i>218-56-7126</i>										17. INFORMANT <i>Katherine I. Dorsey, Rt. 1, Box 160,</i>										ADDRESS <i>Newburg, Md.</i>																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>955X Gun shot wound of head</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>---</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>---</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>976X</i>																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																																											
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY Month, Day, Year <i>158 PM 9, 28 1968</i>										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Shot self in head after shooting girl friend</i>																																																											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>farm</i>										21f. LOCATION Street or R.F.D. No. <i>Faulkner</i> City or Town <i>Charles</i> County <i>Md</i> State																																																											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion										22b. DATE SIGNED <i>9.29.68</i>																																																											
ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D.										CHIEF MEDICAL EXAMINER <input type="checkbox"/>										ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>										DEPUTY MEDICAL EXAMINER <input type="checkbox"/>										ADDRESS (Street, city, town, or county)																																							
EXAMINER'S NAME (Type) <i>WERNER U. SPITZ</i>										23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>										23b. DATE <i>Oct. 1, 1968</i>										23c. NAME OF CEMETERY OR CREMATORY <i>Holy Ghost Cemetery</i>										23d. LOCATION (City or Town) <i>Issue, Charles, Maryland</i> (County) (State)																																							
24. FUNERAL DIRECTOR <i>Arehart Funeral Home Inc., La Plata, Md.</i>										ADDRESS										25a. REC'D BY REGISTRAR <i>OCT 3 1968</i>										25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>																																																	

15886

MEMORANDUM FOR THE RECORD

RE: [illegible]

DATE: July 1, 1950

BY: [illegible]

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

REFERENCE: [illegible]

ACTION: [illegible]

REMARKS: [illegible]

APPROVED: [illegible]

SPECIAL AGENT IN CHARGE

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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VR A15ME (5)
10M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										12856		12867			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or Print) <i>Catherine</i>			First		Middle		Last		2a. DATE KNOWN OF DEATH			2b. HOUR			
							<i>FORD</i>		ESTIMATED <input checked="" type="checkbox"/> 9 28 1968			155 p.m.			
3. SEX <i>F</i>		4. RACE <i>N</i>		5. DATE OF BIRTH <i>5-6-1953</i>		6. AGE (In years last birthday) <i>15</i> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year <i>9 28 1968</i>		2d. HOUR <i>3:30</i> p.m.	
7a. BIRTHPLACE (State or foreign country) <i>Charles County</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Charles</i>			M.D.			
10. CITY OR TOWN OF DEATH <i>Faulkner Md</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Physicians Memorial Hosp</i>						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>			13b. COUNTY <i>Charles Faulkner</i>			13c. CITY OR TOWN <i>Faulkner</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER			
14. FATHER'S NAME <i>James J. Ford</i>			First		Middle		Last		15. MOTHER'S MAIDEN NAME <i>Mary J. Thomas</i>			First		Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>—</i>			17. INFORMANT <i>Mary J. Thomas</i>			ADDRESS <i>Faulkner, Md</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Gun Shot Wounds</i> <i>965x</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>981x</i>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year <i>155 (P.M.) 19</i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>shot by boy friend who then shot self</i>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>				21f. LOCATION Street or R.F.D. No. City or Town County State <i>Faulkner Charles Md</i>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>Werner U. Spitz</i>				M.D.				22b. DATE SIGNED <i>9.29.68</i>							
EXAMINER'S NAME (Type) <i>WERNER U. SPITZ</i>				ADDRESS <i>Pomonkey, Md.</i>				DEPUTY MEDICAL EXAMINER <i>Charles Judge</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Oct. 2, 1968</i>				23b. DATE <i>Burial</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart Cemetery-La Plata, Charles, Md.</i>							
24. FUNERAL DIRECTOR <i>Leroy E Berry Johnson</i>				ADDRESS <i>Pomonkey, Md.</i>				25a. REGISTRAR <i>OCT 9 1968</i>							
								25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							

15887

RECEIVED

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12857		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				12868					
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
HERBERT		P.		HENDERSON		9		Month 10 Day 68 Year		11:30 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		Feb. 12, 1903		65 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				Charles					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
La Plata		Physicians Memorial Hosp.		Conductor		Capital Trans					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Md.		Charles		Nanjemoy		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rural			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Charles		H.		Henderson				Mary		F. Knapp	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		578-10-7124		Mr. Alton V. Henderson-Son-Nanjemoy,		Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4109				Coronary Occlusion		9-15-68					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		4201		Pneumonia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from 9-11-1968, to 9-15-1968, that (I) (we) last saw the deceased alive on 9-15-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22e. DATE SIGNED					
E.J. Edelen		M.D.		La Plata, Maryland		9-15-68					
23a. BURIAL, CREMATION, or other disposition		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		9/17/1968		Nanjemoy Baptist Cem.		Nanjemoy, Maryland					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Arehart Funeral Home, Inc.		-La Plata, Md.		DATE		SEP 18 1968		Charles Judge			

2251

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 10. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR	
WILLIAM						HORTON		ESTIMATED <input type="checkbox"/> 9 15 68		25 M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
M	C.	8-27-08		60 YRS.		MONTHS DAYS		HOURS MIN.		9 15 Year 68	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MISS		U.S.A				CHAS.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
BRYANSD.		Physician Hosp.				WORKED FOR RAY BRAC					
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
DC.		3220 Conn Ave									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
SAMUEL		HORTON						CARPIS		PICKENS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO						JOHN		Wife 3220 Conn Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Cerebro Vascular</u>											
4369 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Accident</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Probable - Arterio Sclerosis</u>										9-15-68	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
331X											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
				HOUR A.M. P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED			
EXAMINER'S NAME (Type)		F J EDELEN M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		9-13-68			
		ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		9-21-68		Lincoln Memorial Cem. Harmony Memorial Park		Prince Georges		Md.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
+ R. Hines Funeral Home 3015-15017						SEP 19 1968		J Charles Judge			

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**FOR STATE
HEALTH DEPT.**

12859

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12870

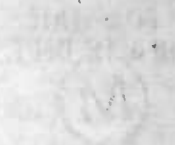
1. DECEASED-NAME (Type or Print) JILL First Middle Last			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year 9 13 68			2b. HOUR 10 M.		
3. SEX F	4. RACE Can.	5. DATE OF BIRTH Dec. 12 1962	6. AGE (In years last birthday) 5 YRS.	IF UNDER 1 YEAR MONTHS 5 DAYS 12	IF UNDER 24 HRS. HOURS 10 MIN. 00	2c. DATE PRONOUNCED DEAD Month 9 Day 13 Year 68		
7a. BIRTHPLACE (State or foreign country) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Charles Md.		
10. CITY OR TOWN OF DEATH La Plata			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Physicians Memorial			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.			13b. COUNTY Chas.			13c. CITY OR TOWN Hughesville YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last Lonnie Lee			15. MOTHER'S MAIDEN NAME First Middle Last Betty Carol Sullivan			16. SOCIAL SECURITY NO. 8164		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS Mrs. Betty C. Kisner, Hughesville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE OF 812.1 DUE TO, OR AS A CONSEQUENCE OF Compromised Cardiovascular system Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. of blood DUE TO, OR AS A CONSEQUENCE OF passenger (c) 9-13-68								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 8164								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Head on rear accident			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 10 P.M. 9-13 1968			21c. HOW INJURY OCCURRED (Enter notes of injury in Part 1 or Part 2, Item 18.) car head on accident		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Highway			21f. LOCATION (Street or R.F.D. No. City or Town County State) Hughesville Charles Md.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE E. J. ESTILLEN			M.D.			22b. DATE SIGNED 9-13-68		
EXAMINER'S NAME (Type)			ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 9-13-68			23c. NAME OF CEMETERY OR CREMATORY OLD FIELDS		
24. FUNERAL DIRECTOR Funeral Home Walda, Md.			ADDRESS			25a. REC'D BY REGISTRAR SEP 20 1968		
						25b. REGISTRAR'S SIGNATURE Charles Judge		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15830

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY



25630 000

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12860

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12871

1. DECEASED-NAME (Type or Print) LONNIE Lee KISNER		First Middle Last		2a. DATE KNOWN OF ESTI- DEATH MATED 9 13 68		2b. HOUR 10 PM	
3. SEX M.	4. RACE Can.	5. DATE OF BIRTH Nov. 5, 1934	6. AGE (In years last birthday) 33 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year 9 13 68	2d. HOUR 10 PM
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Charles	
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Physicians Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Teacher		12b. KIND OF BUSINESS OR INDUSTRY High School	
13a. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) STATE Md.		13b. COUNTY Charles		13c. CITY OR TOWN Hughesville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Lonnie Lee Kisher Sr.		15. MOTHER'S MAIDEN NAME First Middle Last Roxie Virginia Beall					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 7		17. INFORMANT ADDRESS Mrs. Batty C. Kisher, Hughesville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound Comminuted 812.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Fracture of Skull DUE TO, OR AS A CONSEQUENCE OF (c) suicide							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9-13-68
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 8164							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fatal car accident				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year pt 9-13-68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Head on auto accident			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State Hughesville city W.V.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE E. J. Edelen		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 9-14-68			
EXAMINER'S NAME (Type) Edward J. Edelen		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 17, 1968		23c. NAME OF CEMETERY OR CREMATORY Old Fields		23d. LOCATION (City or Town) (County) (State) Hughesville, Chas., Md.	
24. FUNERAL DIRECTOR The Hunt Funeral Home, Waldorf, Md.		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge	
				DATE SEP 20 1968			

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RECEIVED
JAN 10 1968
U.S. AIR FORCE
MEDICAL TRAINING CENTER
FORT MONROE, VIRGINIA

RECEIVED
JAN 10 1968
U.S. AIR FORCE
MEDICAL TRAINING CENTER
FORT MONROE, VIRGINIA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151
30M REV. 1-68

12861										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										12872									
1. DECEASED-NAME (Type or print) First Middle Last										2a. DATE OF DEATH										2b. HOUR									
LONNIE LEE KISNER SR.										Sept 17 1968										11 A M									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS														
MALE			CAU.			AUG 18, 1898			70 YRS.			MONTHS DAYS			HOURS MIN														
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
WEST VIRGINIA			U. S. A.						CHARLES						Md.														
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY																				
LA PLATA			PHYSICIANS MEM. HOSP.			INSPECTOR			SAWMILL																				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER																	
MD.			CHARLES			LA PLATA						NONE																	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last																										
HIRAM KISNER			FLORENCE MOYER																										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address																							
NO			225-01-5831			ROXIE KISNER, LA PLATA, MD.																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease. DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial infarction. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min. 1 year. 3 yrs.																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																							
22a. I certify that (I) (this hospital) attended the deceased from July, 1968, to Sept 17, 1968, that (I) (we) last saw the deceased alive on Sept 17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE			22c. DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22d. DATE SIGNED																				
ARTHUR O. WOODDY, MD									17 Sept 68																				
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS																										
ARTHUR O. WOODDY, MD			LA PLATA, MARYLAND, 20646																										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)																				
BURIAL			9-19-68			TRINITY MEM. GARDENS			WALDORF, CHARLES, MD.																				
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE																				
HUNTT FUNERAL HOME			WALDORF, MD.			SEP 20 1968			J Charles Judge																				

15875

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE CENSUS

UNITED STATES DEPARTMENT OF COMMERCE

1917



RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE CENSUS
UNITED STATES DEPARTMENT OF COMMERCE
WASHINGTON, D. C.

SEP 20 1917

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office during with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12862

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12873

1. DECEASED-NAME (Type or Print) JOE SEPH		First ALBERT		Middle KNOTT		Last		2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year Sept. 30, 1968			2b. HOUR 9:00	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MARCH 19, 1905		6. AGE (In years last birthday) 63 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD Month Sept. Day 30 , Year 1968			2d. HOUR 9:00
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Charles Md.						
10. CITY OR TOWN OF DEATH LA PLATA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) LaPlata Jail				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FARMER			12b. KIND OF BUSINESS OR INDUSTRY TOBACCO			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Hughesville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
14. FATHER'S NAME First JAMES Middle HENRY Last KNOTT				15. MOTHER'S MAIDEN NAME First GEORGIANA Middle DAVIS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 578-24-5676		17. INFORMANT WILLIAM H. KNOTT, HUGHESVILLE, MD.				ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatty Metamorphosis of Liver 571.8 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5810												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.				City or Town		County		State
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED September 30, 1968		
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10-2-68		23c. NAME OF CEMETERY OR CREMATORY ALL FAITHS CEM.				23d. LOCATION (City or Town) MECHANICSVILLE, MD.		(County)		(State)
24. FUNERAL DIRECTOR HUNT FUNERAL HOME, WALDORF, MD.				ADDRESS				25a. REC'D BY REGISTRAR DATE OCT 3 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

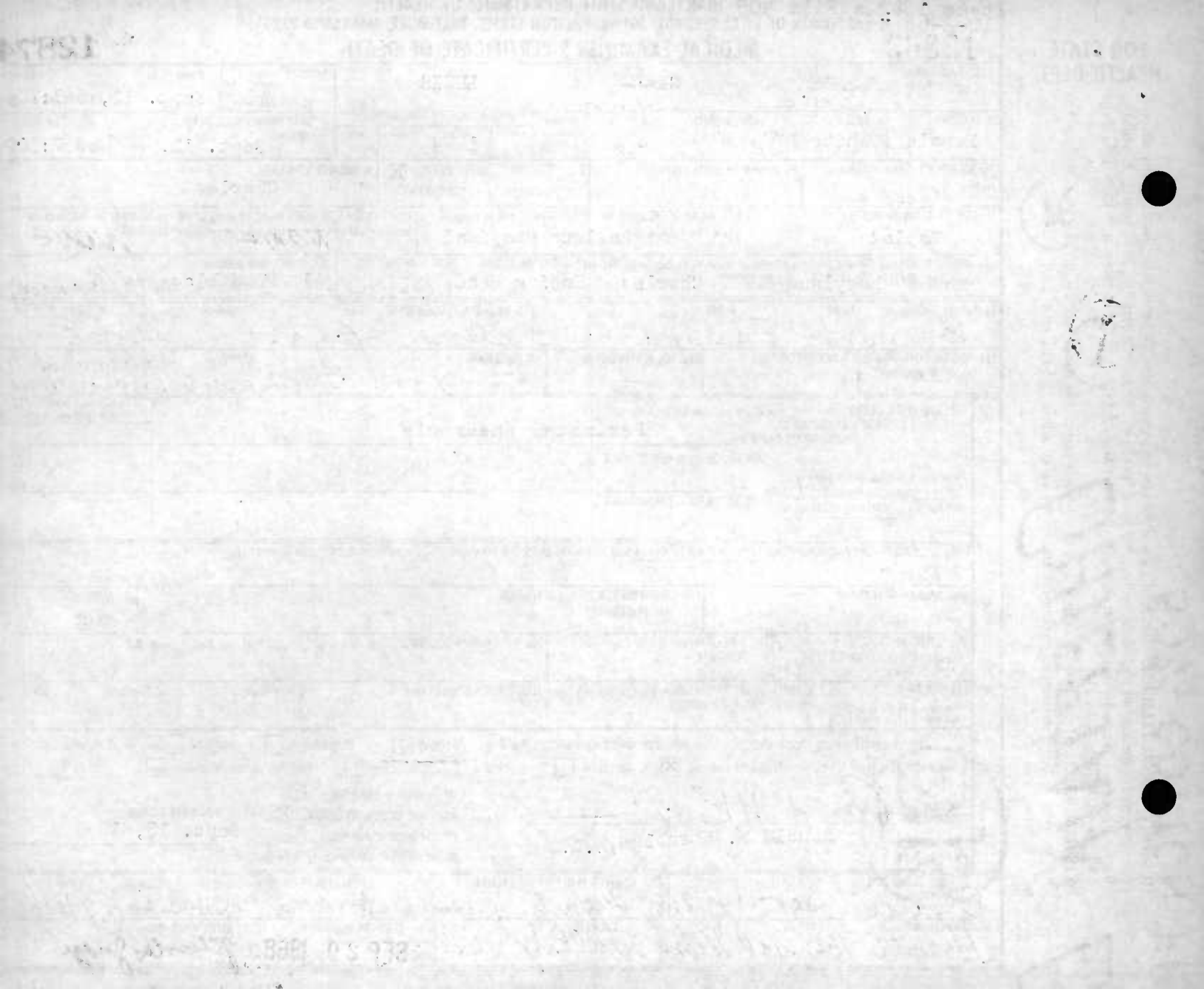
10-2-68 18822a Film 405 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12863

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12874

1. DECEASED-NAME (Type or Print) BADY First GIRL Middle Last Jodie Lynn LEWIS		2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> Sept. 12, 1968		2b. HOUR 7:30p	
3. SEX Female	4. RACE White	5. DATE OF BIRTH Sept. 12, 1968	6. AGE (In years last birthday) 1 YRS. <input type="checkbox"/> MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN.	7c. DATE PRONOUNCED DEAD Sept. 12, 1968	2d. HOUR 7:30p
7a. BIRTHPLACE (State or foreign country) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Charles		MD.
10. CITY OR TOWN OF DEATH Lapata	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) LaPlata Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NONE	12b. KIND OF BUSINESS OR INDUSTRY NONE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Charles	13c. CITY OR TOWN Indian Head	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 410 Wood Place 14 Kenwood	
14. FATHER'S NAME Bernard Edward Lewis		15. MOTHER'S MAIDEN NAME Dora Agnes Jones		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —	
17. INFORMANT Bernard E. Lewis		ADDRESS 14 Kenwood Pl. Indian Head		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perinatal pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) 486X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 763.0	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 19 P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Ronald N. Kornblum		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED Sept. 13, 1968	
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept. 14, 1968	23c. NAME OF CEMETERY OR CREMATORY Trinity Memorial Gardens	23d. LOCATION (City or Town) Waldorf, Md.	(County) (State)	
24. FUNERAL DIRECTOR Hunt Funeral Home, Waldorf, Md.		25a. REC'D BY REGISTRAR SEP 20 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12862

Item#5, Film#G404 9/11/68 km

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

128755

1. DECEASED-NAME (Type or print) MARTHA			First Middle Last			2a. DATE OF DEATH Month September Day 3 Year 1968			2b. HOUR 12:45 A.M.						
3. SEX F			4. RACE Negro			5. DATE OF BIRTH Aug. 25, 1886 1881			6. AGE (In years last birthday) 81 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Charles Md.						
10. CITY OR TOWN OF DEATH La Plata			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Physicians Memorial			12a. USUAL OCCUPATION (Kind of work done during most of working life or if retired.) House Wife			12b. KIND OF BUSINESS OR INDUSTRY At Home						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Charles			13c. CITY OR TOWN La Plata			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER			
14. FATHER'S NAME First Middle Last Unkown			15. MOTHER'S MAIDEN NAME First Middle Last Unkown												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 578-44-0517			17. INFORMANT Mrs. Mary E. Burnett-Daughter La Plata, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis heart disease. DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min 10 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 9/2 , 19 68 , to 9/3 , 19 68 , that (I) (we) last saw the deceased alive on 9/2 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Arthur C. Woody			DEGREE MD			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 3 Sept 68						
22d. PHYSICIAN'S NAME (Type) ARTHUR C. WOODY, MD			22e. ADDRESS LA PLATA, MARYLAND 20646												
23a. BURIAL, CREMATION, or other disposition (Specify) Burial			23b. DATE 9/6/1968			23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery			23d. LOCATION (City or Town) (County) (State) La Plata, Md.						
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc. - La Plata, Md.			ADDRESS			25a. REC'D BY REGISTRAR SEP 6 1968			25b. REGISTRAR'S SIGNATURE Charles Judge						

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CLIMATE OF FLA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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12865		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				12876			
1. DECEASED-NAME (Type or print) JAMES HENRY PICKERAL						2a. DATE OF DEATH Month 9 Day 13 Year 68		2b. HOUR 3-40A-M	
3. SEX M		4. RACE White		5. DATE OF BIRTH July 26, 1900		6. AGE (In years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Charles Md.			
10. CITY OR TOWN OF DEATH LA PLATA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Physicians Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Merchant		12b. KIND OF BUSINESS OR INDUSTRY GROCERY STORE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY Charles		13c. CITY OR TOWN Waldorf		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt. 2 Box 141	
14. FATHER'S NAME First Middle Last James Reese Pickeral		15. MOTHER'S MAIDEN NAME First Middle Last FRANCES VIRGINIA Willett							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 220-32-6326 A		17. INFORMANT Address MRS. ELSIE MAY PICKERAL-WALDORF Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Congestive Heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4200 (b) Arteriosclerotic Heart Disease. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Severe Anemia.									
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 9/7/1968 to 9/13/1968 , that (I) (we) last saw the deceased alive on 9/12/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE N. Bhaduri, M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9/13/68.			
22d. PHYSICIAN'S NAME (Type) NAREN. BHADURI		22e. ADDRESS Waldorf, MD 20601							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE Sept. 16, 1968		23c. NAME OF CEMETERY OR CREMATORY Waldorf		23d. LOCATION (City or Town) (County) (State) Waldorf Charles MD			
24. FUNERAL DIRECTOR Hunt Funeral Home		ADDRESS Waldorf, Md.		25a. REC'D BY REGISTRAR DATE SEP 20 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 1 & 15, Inform. DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
12866 taken from birth cert. 10/8/68 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12877

1. DECEASED NAME (Type or Print) JOYCE Lawarn / A. Carmela PICKERAL		First Middle Last		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 9/30 1968		2b. HOUR 1:00 p. M.			
3. SEX female	4. RACE Negro	5. DATE OF BIRTH 7/17/1968	6. AGE (In years last birthday) YRS. 2-13	IF UNDER 1 YEAR MONTHS DAYS 2-13	IF UNDER 24 HRS. HOURS MIN. 13	2c. DATE PRONOUNCED DEAD Month Day Year September 20, 1968		2d. HOUR 1:00 p. M.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Charles			
10. CITY OR TOWN OF DEATH LaPlata			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Physicians Memorial			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Charles		13c. CITY OR TOWN Waldorf		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME Martin Steward			15. MOTHER'S MAIDEN NAME Joyce Mae Pickeral		13e. STREET AND NUMBER Waldorf, Maryland				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mother - Waldorf, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 512x Interstitial Pneumonitis (SDII) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 525x									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Werner U. Spitz		EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 10/1/68			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 2, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Peter's Ch. Cemetery		23d. LOCATION (City or Town) (County) (State) Waldorf, P. Geo. Md.			
24. FUNERAL DIRECTOR Martell Adams Aquasco, Md.				25a. REC'D BY REGISTRAR OCT 3 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

15877

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

NATIONAL CENTER FOR HUMAN DEVELOPMENT

HEALTH, EDUCATION AND WELFARE

DATE

TIME

LOCATION

REASON FOR VISIT

NAME OF SUBJECT

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

POLITICAL AFFILIATION

ETHNIC ORIGIN

LANGUAGE

RELIGIOUS BELIEFS

SEXUAL ORIENTATION

DIETARY HABITS

EXERCISE HABITS

TOBACCO USE

ALCOHOL CONSUMPTION

DRUG USE

CRIMINAL RECORD

PSYCHIATRIC HISTORY

PSYCHOLOGICAL TESTS

PHYSICAL EXAMINATION

LABORATORY TESTS

IMMUNIZATION RECORD

VACCINATION HISTORY

GENETIC TESTING

ANTHROPOLOGICAL DATA

PHYSIOLOGICAL DATA

PSYCHOPHYSIOLOGICAL DATA

NEUROLOGICAL DATA

ENTOMOLOGICAL DATA

PALEONTOLOGICAL DATA

ARCHAEOLOGICAL DATA

ETHNOGRAPHIC DATA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
12867
12878
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Baby Girl PROCTOR		2a. DATE OF DEATH 9 Month 20 Day 68 Year		2b. HOUR 1:35 P.M.	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH September 20, 1968	
6. AGE (In years last birthday) — YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Charles, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Charles		10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Physicians Memorial Hospital	
12a. USUAL OCCUPATION (Kind of work done during life, even if retired.) None		12b. KIND OF BUSINESS OR INDUSTRY None		13a. CITY OR TOWN Pisgah	
13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET AND NUMBER		13d. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	
14. FATHER'S NAME First Middle Last JAMES SMITH		15. MOTHER'S MAIDEN NAME First Middle Last Lourina Proctor		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO. None		17. INFORMANT Mr. James Smith-Father-		Address 3111 Naylor Rd. Wash., D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Low birth wt. 6 hours 7769 DUE TO, OR AS A CONSEQUENCE OF Failure of lungs to expand properly 6 hrs. (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 7620					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	
21f. LOCATION Street or R.F.D. No. City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from 9-20-1968, to —, 19—, that (I) (we) last saw the deceased alive on 9-20-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE F.M. JOHNSON MD	
22c. DATE SIGNED 9-22-68		22d. PHYSICIAN'S NAME (Type) F.M. JOHNSON MD		22e. ADDRESS LA PLATA, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/23/1968		23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery	
23d. LOCATION (City or Town) (County) (State) Pomfret, Maryland		24. FUNERAL DIRECTOR Arehart Funeral Home, Inc.-La Plata, Md.		25a. REC'D BY REGISTRAR DATE SEP 26 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	

THE NEW YORK PUBLIC LIBRARY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remain on carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12868		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		12879	
CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print) First Middle Last PATRICK FRANCIS ROWAN			2a. DATE OF DEATH Month Day Year 9 25 68		2b. HOUR M
3. SEX Male	4. RACE W	5. DATE OF BIRTH Nov 15, 1887		6. AGE (In years last birthday) 90 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) PA.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Charles	
10. CITY OR TOWN OF DEATH LA PLATA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital or on street address) Physicians Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Electrician	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY Charles White Plains		13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last Michael I ROWAN		15. MOTHER'S MAIDEN NAME First Middle Last KATHERINE KYNE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 144-09-5894A		17. INFORMANT JOHN P. ROWAN WHITE PLAINS, MD.	
18. CAUSE OF DEATH (Enter only one cause per line 18(a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 4369 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sen Ant Sclerosis</u> Chronic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9-22-68
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 331X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE E. J. EDELEN		DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED 9-26-68	
22d. PHYSICIAN'S NAME (Type) E. J. EDELEN		22e. ADDRESS La Plata Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-30-1968		23c. NAME OF CEMETERY OR CREMATORY VINCENTS	
24. FUNERAL DIRECTOR Sunset Funeral Home - Waldorf, Md		ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 27 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

15853

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DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please to have carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12869

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12880

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
James Bowie Shelton						9-20-68			5:30A M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		White US.		April-26-1899		69 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Charles County Md.					
Virginia		USA.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
LaPlata Md		Physicians Memorial		Retired		US-Govt.					
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland		Charles		Indian Head		NO <input type="checkbox"/>		1002 Straus Avenue			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
James W. Shelton						(Unknown)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		223-14-2148		Wife-Ann W. Shelton-Indian Head Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Gastro-Enteritis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>473 X</u> (b) <u>Influenza- Gastro-intestinal</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>472 X</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8-Days</u> <u>8-Days</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Cirrhosis Liver</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>9-15-68</u> , 19 <u>68</u> , to <u>9-20-68</u> , 19 <u>68</u> , that (I) <u>too</u> lost saw the deceased alive on <u>9-20-68</u> , 19 <u>68</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) <u>not</u> view the body after death.											
22b. SIGNATURE <u>James E. Andrews MD</u>		22c. DATE SIGNED 9-20-68		22d. PHYSICIAN'S NAME (Type) James E. Andrews MD							
				22e. ADDRESS Indian Head Md.							
23a. BURIAL, CREMATION, RESURRECTION (City)		23b. DATE 9/23/1968		23c. NAME OF CEMETERY OR CREMATORY Nazerine Cemetery		23d. LOCATION (City or Town)		(County)		(State)	
Burial						Pisgah, Maryland					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Arehart Funeral Home, Inc.-La Plata, Md.								DATE SEP 24 1968		<u>Charles Judge</u>	

15880

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12870		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				12881	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <i>Bert HA</i>			First Middle Lost <i>Stoger</i>			2a. DATE OF DEATH 9 Month 2 Day 68 Year	
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH 1-16-93		6. AGE (In years last birthday) <i>75</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>HUNGARY</i>		7b. CITIZEN OF WHAT COUNTRY? <i>Hungary</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Charles</i> Md.	
10. CITY OR TOWN OF DEATH <i>La Plata</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>St. Charles Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>House Wife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Charles</i>		13c. CITY OR TOWN <i>Potomac Hgts.</i>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>18 Delta Place</i>		14. FATHER'S NAME First Middle Lost (<i>Unkown</i>) <i>Sieler</i>		15. MOTHER'S MAIDEN NAME First Middle Lost (<i>Unkown</i>)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>081-20-2644</i>		17. INFORMANT <i>41 Cypress Place Louis P. Stoger-Son Potomac Hgts., Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>402X CONGESTIVE HEART FAILURE</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>HYPERTENSION</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8-18-68</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>443X</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>8-18-68</i> , to <i>9-2-68</i> , that (I) (we) last saw the deceased alive on <i>9-2-68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>E J EDELEN</i>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>9/4/1968</i>			
22d. PHYSICIAN'S NAME (Type) <i>E J EDELEN</i>		22e. ADDRESS <i>La Plata, Maryland</i>					
23a. BURIAL, CREMATION, or other disposal (Specify) <i>Burial</i>		23b. DATE <i>9/7/1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Charles Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Glymont, Maryland</i>	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
Arehart Funeral Home, Inc.-La Plata, Md.				DATE <i>SEP 6 1968</i>			

15881

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used of a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12872

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12882

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 9/26 1968		2b. HOUR 11:30 A. M.	
LYNN						THOMAS					
3. SEX male	4. RACE negro	5. DATE OF BIRTH 12-22-18		6. AGE (In years last birthday) 49 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year September 26, 1968	
7a. BIRTHPLACE (State or foreign country) WARENTON VA.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Charles				2d. HOUR 11:30 A. M.	
10. CITY OR TOWN OF DEATH CHARLES County		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) LaPlata Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER		12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.		13b. COUNTY V		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2709 Bruce Pl., S.E.			
14. FATHER'S NAME ANTHONY THOMAS		First		Middle		Last		15. MOTHER'S MAIDEN NAME —		First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT JEAN EATON		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries 916x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 910.3											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 9:45 AM 9/26/19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) working in a ditch when it caved in. Subj.							
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) ditch		21f. LOCATION Street or R.F.D. No.		City or Town		County		State Charles, Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Werner U. Spitz, M.D.		22b. DATE SIGNED 9/27/68		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10/2/68		23c. NAME OF CEMETERY OR CREMATORY CHURCH CEMETERY		23d. LOCATION (City or Town) WARENTON VA.		(County)		(State)	
24. FUNERAL DIRECTOR W. F. Bacon 3447 14th St N.W.		ADDRESS Washington D.C.		24a. RECD BY REGISTRAR DATE SEP 30 1968		24b. REGISTRAR'S SIGNATURE Charles Judge					

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UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS
NATIONAL CENTER FOR VITAL STATISTICS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12873		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				12884	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <i>GLENN WALTER VARNADO</i>		2a. DATE OF DEATH Month <i>8</i> Day <i>04</i> Year <i>1968</i>		2b. HOUR <i>10A</i> M.			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>May 9, 1905</i>		6. AGE (In years last birthday) <i>63</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Louisiana</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Charles</i>	
10. CITY OR TOWN OF DEATH <i>La Plata</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Physicians Mem. Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Painter</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Charles</i>		13c. CITY OR TOWN <i>Indiana Head</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13e. STREET AND NUMBER <i>44 Mattingley Avenue</i>		14. FATHER'S NAME First <i>Walter</i> Middle <i>Scott</i> Last <i>Varnado</i>		15. MOTHER'S MAIDEN NAME First <i>Lela</i> Middle <i>Farrell</i> Last <i>Farrell</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <input checked="" type="checkbox"/> Yes (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>425-12-2271</i>		17. INFORMANT Address <i>Indian Head, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lymphosarcoma</i> <i>2001</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>2001</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>9-5</i> , <i>1968</i> , to <i>9-8</i> , <i>1968</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>E.J. Edelen</i> DEGREE <i>E.J. Edelen, M.D.</i>		22c. DATE SIGNED <i>9/8/1968</i>			
22d. PHYSICIAN'S NAME (Type) <i>E.J. Edelen, M.D.</i>		22e. ADDRESS <i>La Plata, Maryland</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9/11/1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Osyke Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Osyke, Mississippi</i>	
24. FUNERAL DIRECTOR <i>Archart Funeral Home, Inc. - La Plata, Md.</i>		25a. REC'D BY REGISTRAR <i>SEP 10 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12872		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				12883	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or Print) HUGH		First R.		Middle WILMER		Last	
3. SEX M	4. RACE W	5. DATE OF BIRTH 7-28-97	6. AGE (In years last birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month 9 Day 23 Year 1968	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		2c. DATE PRONOUNCED DEAD 9-23-68 Month 9 Day 23 Year 1968	
10. CITY OR TOWN OF DEATH Hughesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY Charles		13c. CITY OR TOWN Hughesville		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME PERE		First WILMER		15. MOTHER'S MAIDEN NAME AMELIA		First MATTHEWS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) Yes		16b. SOCIAL SECURITY NO. 212-52-2980		17. INFORMANT Mr. Joseph A. Wilmer-Son/Schiller Pk.		10130 Ivanhoe Court	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) CRUSHED CHEST & INTERNAL HEMORRHAGE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. WORKING UNDER JACKED UP CAR WHICH FELL ON HIM DUE TO, OR AS A CONSEQUENCE OF (b) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 9100							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year 10-29-68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) CAR FELL ON HIM			
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) HOME-FARM		21f. LOCATION Street or R.F.D. No. HUGHESVILLE MD CHAS		City or Town La Plata County Charles State Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE E. J. EDELEN		EXAMINER'S NAME (Type) E. J. EDELEN MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 9-23-68	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/26/1968		23c. NAME OF CEMETERY OR CREMATORY Mt. Rest Cemetery		23d. LOCATION (City or Town) (County) (State) La Plata, Maryland	
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc.-La Plata, Md.				25a. REC'D BY REGISTRAR SEP 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MICRO EXAMINING METHOD OF WORTH

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